NORTH YORKSHIRE COUNTY COUNCIL

CARE AND INDEPENDENCE OVERVIEW AND SCRUTINY COMMITTEE

24 SEPTEMBER 2020

HAS FINANCIAL POSITION

1.0 Purpose of Report

1.1 This paper highlights the current financial position facing HAS as at September 2020, describes the impact COVID-19 costs are having on the in-year position and also describes the management action that is being taken in response to ongoing pressures.

2.0 HAS Financial Pressures

2.1 At its meeting on 25 August 2020, the Executive received the Quarterly Performance and Budget Monitoring Report for Q1, 2020-21. The report highlighted a net projected overspend in Health and Adult Services of £11.2m. The HAS budget includes Adult Social Care, Public Health and some whole directorate costs and these are dealt with separately below.

2.2 However behind this net estimate are a number of figures which need to be highlighted.

2.3 In recent years, the Council has received temporary funding such as Improved Better Care Fund (IBCF) and Winter Pressures Grant. Although much of the IBCF is used for specific projects, working alongside Health partners, some is used to mitigate the financial pressures in Adult Social Care, as is Winter Funding. In the current 2020-21 projections, it is assumed that the following amounts are supporting the pressures and therefore have reduced the net overspend by these amounts:

- £0.55m of IBCF
- £2.4m Winter Pressures
- £1.6m Growth allocated by NYCC to support Winter Pressures

2.4 Winter Pressures funding and IBCF is only guaranteed to continue for the current financial year (2020-21) and, whilst there is some expectation of similar funding continuing to offset budget pressures in the future, this is not guaranteed.

2.5 Th £11.2m projected overspend reflects COVID-19 related budget pressures of £13.9m and non-COVID net underspends of £2.7m relating to business as usual activity. It also assumes that costs of £9.5m will be funded by NHS as part of the government's support to costs incurred in keeping people out of hospital.

2.6 Costs that are described as COVID-19-related include:

- Payments to providers of an extra 5% (April – Aug) then 2.5% in September **(£4m)**
- Expected costs passing to Adult Social Care as those who are funded by NHS are assessed and become our financial responsibility **(£4.8m)**
- Extra staffing required **(£2.3m)**
- Adult Social Care savings as agreed in the Council's MTFS but now unlikely to be achieved this year **(£1.6m)**

2.7 These figures are consistent with the estimated position at Q1 and are constantly changing. For example, due to the extension of hospital discharge funding announced in August, our net costs could reduce. However current increases in case numbers (at time of writing) may also increase the cost.

2.8 In recent years the council has relied on the temporary funding to ensure that the directorate outturn remains close to a break-even. Without such funding the HAS figures would have shown overspends of £4.7m in 2018-19 and £7.3m in 2019-20. (These net figures do not include pressures on the Public Health budget described separately below.)

2.9 Therefore, even with the additional funding of £4.55m described in 2.3 above, it might be tempting at first glance to regard the "business as usual" underspend of £2.7m as an improvement in the directorate's financial position.

2.10 The Directorate instituted a financial recovery plan during 2019-20 and this is being significantly revised and expanded in response to the pressures which emerged in the second half of the last financial year. Further details of this are set out in section 3 of this report and actions are beginning to have an impact on tighter practice.

2.11 However, non-financial performance suggests that a large contributory factor to the "business as usual" underspend is reduced activity – as a result of COVID. Therefore while the council is seeing increased costs directly related to COVID as described in 2.6 above, reduced activity is having the opposite effect. Examples of these – as at July – are shown in the table below :

Contacts and Referrals	• 21,740 contacts in the year to date: down 14.5% on July 2019 • 74.1% of contacts led to a referral (2019-20 was 74.1%) • 4,611 referrals year to date, down 30% on July 2019
Living Well	• 46% reduction in referrals for April – June • 39% reduction in referrals for April – July

2.12 At the same time however we continue to see increased market pressures:

- 62% of new admissions have been placed above NYCC rates
- Those areas above the county average are Selby, Harrogate and Craven
- 54% of current placements are above NYCC rates (was 50% in September 2019)

2.13 The main variances are shown in Appendix 1 to this report, which also highlights COVID costs

Public Health

2.14 Public Health has a gross budget of £23.5m but is balanced to a net zero in the Council's Quarterly monitoring reports. The Public Health grant has reduced in real terms in recent years and is currently £22.1m. The difference is being funded from reserves. This is a planned use of the earmarked reserve which was built up in previous years. Nevertheless it means that current spend will have to be reduced by at least £1.4m by 2022-23 to be in line with the grant – and more if further savings are required.

2.15 The Q1 figures show that as activity has reduced, so have costs, leading to a projected underspend on original budget of £400k, despite not making £500k of savings originally envisaged. This will help with use of reserves but further action is still required to bring costs into line with funding.

2.16 As part of this, the Council has been looking at some of its major contracts such as Health Child and Sexual Health, working with partners to ensure that efficiencies are built into the new models expected to be in place in the next few years.

3.0 Budget Recovery Plan

3.1 As reported to previous meetings of the Committee, the Directorate has an action plan which aims to reduce the financial pressures in Care and Support, while continuing to look for other savings to support the Council's overall budget position. This plan focuses on three key areas. One of these – the **Market** – is highlighted above. The other areas are **Practice** and **Productivity.**

3.2 In terms of **Practice**, we are on a ten-year journey to ensure our practice is confident and consistent. We have made a good start in introducing a Strength-Based Assessment (SBA). SBA is about making an assessment on the basis of what the individual can do, what support they can get from their family, friends and community and, only then, looking at how that can be enhanced by a care package - a radically different type of practice from the social care provided since the 1990 NHS & community care act took effect in April 1993.

3.3 We will also ensure that standards of **Productivity** are high right across the entire Council. We will make best use of technology. To minimise the number of assessments which end before completion (one in four), we will strengthen our so-called "front door" arrangements. This is where we can quickly make decisions about which route to take with different social care contacts and referrals and therefore reduce unproductive effort.

3.4 A revised Recovery Plan is currently being finalised but is likely to focus on the following areas:

Making Budget Management Work

- Revised Scheme of Delegation
- Budget Management Skills
- Improved Forecasting and other business processes

Improving Budgetary Control in Practice

- Improved data monitoring and budget tracking
- Development of a budget performance and activity dashboard
- Practice Review meetings
- Introduction of training materials
- Professional Reasoning checklist
- Closer scrutiny of adult social care activity, practice and performance
- Clear exit strategies for temporary funding and projects
- Ensuring the correct split of costs between NYCC and NHS (especially Continuing Health Care) and people who use our services

4.0 Funding

4.1 Our areas of concern regarding the future of Adult Social Care funding remain as then and are repeated here for ease of reference.

4.2 As set out last year, we continue to lobby central government for a fairer funding settlement in this respect.

4.3 In all of these discussions, our message has been that in future any funding settlement must be comprehensive, enduring and fair settlement for social care. It should also be less complex than the current system which is a mixture of one-off and recurrent funding, ring-fenced and non-ringfenced grants, local ability to raise additional Council Tax and contributions from service users.

4.4 We have also said that there needs to be a review of the funding allocations formula, with Adult Social Care funding based on ageing and disabled population and Public Health Grant funding based on indices of multiple deprivation.

4.5 Consideration should be given of additional cost pressures facing local government and the NHS in remote rural and coastal communities. Any funding formula should take into account the different costs of delivery incurred by geography and supply, for example higher transport costs and an older population. We also endorse the LGA and PHE report from 2017 (https://www.local.gov.uk/health-and-wellbeing-rural-areas) which notes, amongst other conclusions, that:

- Both sparsity and rurality appear to affect poverty levels and consequently the health of people in rural areas. Sparse areas on the fringes of towns and urban settlements have the highest proportions of poor households, although no area type is poverty free.

- Changing population patterns, including outward migration of young people and inward migration of older people, are leading to a rural population that is

increasingly older than the urban population, with accompanying health and care needs.

- Sparsity and the increasing scarcity of public transport links have a significant impact both on daily living costs of rural households and on access to services.

- Rural areas have worse access in terms of distance to health, public health and care services. Longer distances to GPs, dentists, hospitals and other health facilities mean that rural residents can experience 'distance decay' where service use decreases with increasing distance. Different models of service delivery may be needed for rural areas, including new models of workforce development. These also include the development of rural hubs providing a range of services, and more services provided on and through the internet.

4.6 We have also advised that we need to review and decide what is the responsibility and resulting costs of the state and what we agree should fall on individuals and families. In this we need to reflect on charges to people and revisit means test and needs test thresholds. We should be cautious about the unintended consequences of including people's homes in financial assessments for home care.

4.7 Finally, there needs to be clarity – not least for the general population – about the respective roles of the health and social care sectors and how much people will have to pay to access these. Expectations are understandably confused when some health care is free without means-testing while this is not currently the case in social care provision.

6.0 Recommendations

6.1 Overview and Scrutiny Committee is asked to note the contents of the report.

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APPENDIX 1: HAS DIRECTORATE POSITION AS AT Q1 2020-21

BUDGET HEAD	REVISED BUDGET 2020-21 £000	FORECAST OUTTURN 2020-21 £000	VARIANCE (-) = saving £000	COVID Costs
Care & Support				
- Area Budgets				
Care & Support - Hambleton & Richmond	27,725	27,877	152	336
Care & Support - Selby	14,433	14,776	342	212
Care & Support - Scarborough, Whitby & Ryedale	44,962	45,314	352	691
Care & Support - Harrogate	39,552	43,407	3,855	330
Care & Support - Craven	12,804	13,582	778	185
CHC Income and Other Budgets		(545)	(545)	400
Area Budgets	139,477	144,412	4,935	2,153
Provider Services & EC/PCAH	15,096	15,914	818	943
Targeted Prevention	1,510	1,463	(46)	13
Mental Health Services	9,186	10,110	925	900
Assistant Director/Cross-area budgets	(10,768)	(10,783)	(15)	81
COVID-19 costs		9,619	9,619	9,619
Area Budgets Total	**154,500**	**170,735**	**16,236**	**13,709**
Public Health				
- Spend	23,518	23,106	(412)	
- Income	(23,518)	(23,106)	412	
Commissioning & Quality	7,912	7,437	(475)	214
Integration & Engagement	895	851	(43)	
Resources Unit	561	544	(17)	
Director & Cross-Directorate	197	205	8	
TOTAL	**164,064**	**179,773**	**15,709**	**13,924**
Supplementary Adult Social Care Grant Funding and Growth	4,000	-	(4,000)	
Supplementary Adult Social Care Grant Funding (IBCF)		(550)	(550)	
REVISED TOTAL	**168,064**	**179,223**	**11,159**	**13,924**